HEALTH HISTORY QUESTIONNAIRE - All information is strictly confidential

GENERAL PATIENT INFORMATION

Date: ____/____/____

Name: _____ E-mail Address: _____

Address: _____ City, State, Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

Age: _____ Date of Birth: _____/_____/_____ Place of Birth: _____

Guardian (if under 18): _____

Gender: ☐M ☐F ☐Neutral Height: _____ Weight: _____

Occupation: _____

Employer: _____

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Do these condition impair your daily activities? ☐Yes ☐No

Patient Medical History

How was your childhood health? _____

Hospitalization(s): _____

Recent test: (Please indicate the test result and date below)

☐Physical ☐Cholesterol ☐Blood (Which?) Other:

_____

Test Result and Date: _____

Check any you have had in the past:

☐Diabetes	☐Allergies	☐Glaucoma	☐Rheumatic Fever
☐Heart Disease	☐CVA (stroke)	☐Vein condition	☐Thyroid disorder
☐Asthma	☐Pneumonia	☐Tuberculosis	☐Emphysema
☐Jaundice	☐Gonorrhea	☐Mumps	☐Bleeding tendency
☐Measles	☐Chicken Pox	☐Nervous disorder	☐Mononucleosis
☐Meningitis	☐HIV	☐Polio	☐Multiple Sclerosis
☐Paralysis	☐High Fever	☐Hepatitis	☐High blood pressure
☐Other Lung illnesses	☐Cancer	☐Migraines	☐Other Kidney illnesses
☐Epilepsy	☐Other Liver illnesses	☐Other Hearth illnesses	

Physical Traumas: _____

Emotional Traumas: _____

Surgeries: _____

Immunization: _____

Family medical history

	You	Your Relative	Approx. Date		You	Your Relative	Approx. Date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Diseases	☐	☐	_____	Tuberculosis	☐	☐	_____

Please indicate any significant illnesses your or a blood relative (Grandparent, parent or sibling) have had:

STD

Sexually Transmitted Diseases: ☐Gonorrhea ☐Syphilis ☐AIDS ☐HPV ☐Chlamydia ☐Herpes Date _____

Medications

List any medication and supplements you are currently taking:

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

coffee/alcohol/tobacco

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/black tea	☐	☐	_____	Tobacco	☐	☐	_____	Water Intake	☐	☐	_____
Non-medical drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda pop	☐	☐	_____

How do you feel about the following areas of your life?

How do you FEEL about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing

	Great	Good	Fair	Poor	Bad	Your Comments
Significant						
Other	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

Diagnostic questions

1. TEMPERATURE

Body	___Hot	___Cold	STRESS
Hands	___Hot	___Cold	[1-10]
Sweat	___Hands	___Feet	_____
	___Chest	___Flush	_____

2. SLEEP

___Trouble falling asleep	___Wake earlier than norma
___Restless Sleep	___Wake earlier than norma
___Vivid dreams/nightmares	___Wake in middle of night

3. BOWEL MOVEMENTS

___Diarrhea	___Urgency	___ x day
___Loose	___Incomplete	___x week
___Formed	___Blood	___Mucous
___Constipation	___Undigested food	___Black tarry

4. DIET

Servings a day

Red Meat	_____
Chicken/Fish/Eggs	_____
Dairy/Milk/Cheese	_____
Fruit	_____
Vegetables	_____
Whole Grains	_____
Nuts & Seeds	_____
Rice, Pasta, Bread	_____
Sweets	_____

5. URINATION

___Colorless/clear	___Urgency	___Cloudy
___Straw/normal	___Frequent	___Burning/pain
___Dark/concentrated	___Scanty	___Strong Odor
___Reddish	___Profuse	___Discharge

6. APPETITE/THIRST

___Eat breakfast	___Drink water
___No appetite	___No thirst
___Excessive appetite	___Excessive thirst
___Eat after 8:00 p.m.	___Drink after 8:00 p.m.

7. EXERCISE

___Cardio	___Weights
____Yoga	___Walking
____Tai-chi	___Other_____
____x a week	Hours per week_____

For women

Age of 1st period (menarche) _____ Are you pregnant? ☐Yes ☐No # of pregnancies _____

Age of last period (menopause) _____ # of Live births _____ # of Abortions _____ # of Miscarriages_____

Number of days between periods _____ Date of last Gynecologic exam _____ Pap smear _____

Number of days of flow _____ Mammogram _____ Bone Density Scan _____

Color of Flow _____ Results _____

Clots? ☐Yes ☐No Color _____ _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ +day _____

Have you been diagnosed with: ☐Fibroids ☐Fibrocystic breasts ☐Endometriosis ☐Ovarian Cysts ☐PID ☐other

Location of Pain: ☐Lower abdomen ☐Lower back ☐Thighs other _____

Name of Pain: (Please indicate before, during or after menses) Other Symptoms related to menses:

Cramping _____ Stabbing _____ ☐Discharge ☐Vaginal dryness ☐Headache

Burning _____ Aching _____
Dull _____ Bloating _____
Consistent _____ Intermittent _____
Bearing down sensation _____

☐Nausea ☐Constipation ☐Diarrhea
☐Swollen breasts ☐Mood swings ☐Ravenous appetite
☐Poor appetite ☐Hot flashes ☐Night sweats
☐Increased libido ☐Decreased libido ☐Insomnia

For men

Date of last prostate checkup _____ PSA results _____ Manual prostate exam results _____
Lab results _____

☐Prostate problems ☐Delayed stream ☐Dribbling ☐Incontinence ☐Retention of urine
☐Rectal dysfunction ☐Increased libido ☐Decreased libido ☐Premature ejaculation ☐Impotence
☐Back pain ☐Groin pain ☐Testicular pain Other _____

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they related to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalance are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will related only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____